DISCLOSURE TO FAMILY, RESPONSIBLE PARTY OR FOR NOTIFICATION

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PATIENT NAME: ____

D.O.B. ____________________

THE PURPOSE OF THIS FORM IS TO IDENTIFY THE FAMILY MEMBERS OR OTHER PERSONS TO WHOM WE MAY DISCLOSE PROTECTED HEALTH AND/OR FINANCIAL ACCOUNT INFORMATION ABOUT YOU OR NOTIFY REGARDING YOUR CARE.

I AUTHORIZE THE FOLLOING INDIVIDUALS TO ACCESS MY PRVATE MEDICAL AND PERSONAL INFORMATION:

1.) ______________________________ ____________________
Authorize Person: First & Last Name — Relationship

2.) ______________________________ ____________________
Authorize Person: First & Last Name — Relationship

3.) ______________________________ ____________________
Authorize Person: First & Last Name — Relationship

4.) ______________________________ ____________________
Authorize Person: First & Last Name — Relationship

X ______________________________ ____________________
Patient/Parent/Guardian/Power of Attorney Signature — Date

THIS FORM WILL REMAIN IN EFFECT UNTIL THE PATIENT PROVIDES FURTHER WRITTEN NOTICE